

The PEOPLE'S CLINIC

710 1/2 W Franklin St. Ste. B Boise, ID 83702 (208) 409-7759

All information provided on this form and in our clinic will remain strictly confidential.

How did you learn about The People's Clinic? _____

If you were referred by someone, may we thank them for the referral? _____

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home phone _____ Cell Phone/pager _____

E-mail address _____ How shall we contact you? _____

Emergency Contact _____ Relationship _____

Telephone number _____ Alternate number _____

Employer _____ Occupation _____

Doctor _____ Address _____

Please tell us about your health concerns and what brings you to seek treatment today.

In order of importance, please list your three most pressing health concerns:

1: _____

When did this begin? _____ What treatments, medication or supplements, if any, have you taken for this? _____

What makes it better? _____ Worse? _____

2: _____

When did this begin? _____ What treatments, medication or supplements, if any, have you received for this? _____

What makes it better? _____ Worse? _____

3: _____

When did this begin? _____ What treatments, medication or supplements, if any, have you received for this? _____

What makes it better? _____ Worse? _____

What is your opinion about the causes of your health concerns? _____

What are your goals for your health? _____

Please indicate if you have experienced any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chronic pain | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> jaw pain/teeth grinding | <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> scoliosis | <input type="checkbox"/> cancer/tumors |
| <input type="checkbox"/> depression | <input type="checkbox"/> arthritis | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> tendonitis | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> STD's | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> gastrointestinal issues | <input type="checkbox"/> mental health condition | <input type="checkbox"/> hair loss |
| <input type="checkbox"/> weight changes | <input type="checkbox"/> bleeding disorders | <input type="checkbox"/> pace maker |

Please indicate the following:

Caffeine What drink(s)? _____ Frequency _____ per _____

Smoke Currently? _____ When did you quit? _____ How long? _____ Cigarettes per day _____

Alcohol Type? _____ Drinks per week _____ Recreational drug use? _____

Do you eat a special diet? _____

Do you wear a seatbelt every time you are in a car? _____

How much water do you drink per day? _____ Do you wear sunscreen daily? _____

Exercise activities: _____

Women:

- | | | |
|---|--|--|
| <input type="checkbox"/> PMS | <input type="checkbox"/> painful periods | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> breast lumps | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Very heavy periods | <input type="checkbox"/> clotting with periods | |

Are you pregnant? _____ Due date _____ Are you trying to become pregnant? _____

Age you began menstruation _____ Have you reached menopause? When? _____

Number of pregnancies _____ Number of births _____ Birth control method _____

Do you do breast self-exams? _____ Do you get annual Pap smears? _____

Men:

___ Prostate problems ___ Erectile dysfunction ___ Infertility

Do you do testicular self-exams? _____

List all medications/herbs/supplements you are currently taking:

Medication/herb/supplement	Reason	Prescribing practitioner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List previous major injuries/surgeries/illnesses/injuries:

Surgery/Injury/Illness	Date
_____	_____
_____	_____
_____	_____
_____	_____

What other treatments are you receiving and by whom (MD, physical therapy, chiropractic, naturopathic):

What are your main activities at work? On phone ___ Sitting ___ Computer work ___ Driving car _____

Walking _____ Other _____

What do you do to relieve stress? _____

If you were to list one thing you need from our office or your practitioner today, what would that be?

Signature

Date

Printed name

Body Systems Review:

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0 1 2 3 4	low appetite	0 1 2 3 4	ravenous appetite
0 1 2 3 4	loose stools	0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	mouth sores	0 1 2 3 4	fatigue after eating
0 1 2 3 4	abdominal gas/bloating after food	0 1 2 3 4	bruise easily
0 1 2 3 4	gums (bleeding/swollen)	0 1 2 3 4	thirst
0 1 2 3 4	organ prolapsed (diagnosed)	0 1 2 3 4	belching or vomiting

0 1 2 3 4	spontaneous sweat	0 1 2 3 4	fatigue
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	shortness of breath
0 1 2 3 4	general weakness	0 1 2 3 4	cough
0 1 2 3 4	dry nose/mouth/skin/throat	0 1 2 3 4	nasal discharge
0 1 2 3 4	feel worse after exercise	0 1 2 3 4	sinus congestion

0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	feel cold (in core)
0 1 2 3 4	low back pain	0 1 2 3 4	cold hands &/or feet
0 1 2 3 4	frequent urination	0 1 2 3 4	urinary incontinence
0 1 2 3 4	early morning diarrhea	0 1 2 3 4	hearing loss
yes	no	0 1 2 3 4	edema
high	normal	yes	no
low	libido		hair loss

0 1 2 3 4	muscle spasms/twitches	0 1 2 3 4	irritable
0 1 2 3 4	feel better after exercise	0 1 2 3 4	numb extremities
0 1 2 3 4	tight feeling in chest	0 1 2 3 4	dry eyes
0 1 2 3 4	alternating diarrhea/constipation	0 1 2 3 4	ear ringing
0 1 2 3 4	symptoms worse with stress	0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension	0 1 2 3 4	red eyes

0 1 2 3 4	feel heart beating	0 1 2 3 4	chest pain
0 1 2 3 4	insomnia	0 1 2 3 4	disturbing dreams
0 1 2 3 4	sores on tip of tongue	0 1 2 3 4	headaches
0 1 2 3 4	anxiety	0 1 2 3 4	restlessness
0 1 2 3 4	chest pain traveling to shoulder		
high	normal	low	overall body temperature
high	normal	low	overall energy level

0 1 2 3 4	see floaters in eyes	0 1 2 3 4	foggy thinking
0 1 2 3 4	heat in palms or soles	0 1 2 3 4	dizzy upon standing
0 1 2 3 4	feeling of heaviness	0 1 2 3 4	nausea
0 1 2 3 4	afternoon fever	0 1 2 3 4	night sweats
0 1 2 3 4	enlarged lymph nodes	0 1 2 3 4	cloudy urine
0 1 2 3 4	face flushes		

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Signature: _____ Date: _____

The People's Clinic

Donna J. Selle, MS, L.Ac.

Graduate of Bastyr University, Kenmore, WA
ID State License #235

Gretchen Huettig, MSAOM, L.Ac.

Graduate of Bastyr University, Kenmore, WA
ID State License

Please read this information carefully, and ask your practitioner if there is anything you do not understand.

Acupuncture is a form of treatment whereby fine, specialized, sterile needles are inserted through the skin at specific points on the body.

Acupuncture is very safe. Adverse effects are rare. You need to be aware:

- *drowsiness may occur in a small number of patients;*
- *minor bleeding and bruising may occur in less than 1% of treatments;*
- *symptoms can worsen after a treatment, (in less than 3% of patients). If this occurs with you, contact your Acupuncturist promptly;*
- *Faintness and fainting can occur in certain patients, particularly in the first treatment. If you feel faint at any time, tell your practitioner immediately.*

Additionally, if there are particular risks that apply in your case, your Acupuncturist will discuss these with you.

Apart from routine medical details that will be discussed during your intake, it is important you let your Acupuncturist know:

- *if you have ever experienced fainting or are sensitive or nervous about needles;*
- *if you have a pacemaker or any other electrical implants;*
- *if you have a bleeding disorder;*
- *if you are taking any drugs, particularly anti-coagulants, (blood thinners);*
- *if you have damaged heart valves or have any other particular risk of infection.*

Single-use, sterile, disposable needles are used in this clinic.

Other therapies that may be used in your treatment include:

Cupping—a technique used to relieve certain symptoms by applying cups to the skin with a vacuum seal created by heat or a pump.

Guasha—the rubbing of an area of skin on the body with a specialized instrument.

Massage—the manipulation of muscle tissue to cause relaxation and pain relief.

Electro-acupuncture—the use of a very mild electrical current with acupuncture needles.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to receiving acupuncture treatment. I understand I can refuse treatment or an element of a treatment at any time. I acknowledge no guarantees have been given regarding the outcome of my treatment(s). I release Donna J. Selle, L.Ac. from all liability which may occur in connection with the above mentioned procedures.

Signature: _____ Date: _____

Printed Name: _____

The PEOPLE'S CLINIC

FINANCIAL POLICY

THE PEOPLE'S CLINIC MAKES EVERY ATTEMPT TO MAKE ALTERNATIVE HEALTHCARE AVAILABLE TO AS MANY PEOPLE AS POSSIBLE, AT THE MOST AFFORDABLE RATES.

IN RESPECT FOR OUR INTENTION TO OFFER HIGH QUALITY HEALTH CARE AT AFFORDABLE PRICES, WE ASK FOR 24 HOURS NOTICE IN ADVANCE OF AN APPOINTMENT IF IT IS NECESSARY TO CANCEL OR RESCHEDULE AN APPOINTMENT.

ALL APPOINTMENTS THAT ARE RESCHEDULED OR CANCELLED WITH LESS THAN 24 HOUR ADVANCE NOTICE, AND APPOINTMENTS MISSED WITHOUT NOTICE, WILL BE CHARGED A \$15 FEE FOR THAT APPOINTMENT. IF APPOINTMENTS HAVE BEEN PURCHASED IN A PACKAGE, THE MISSED, CANCELLED OR RESCHEDULED APPOINTMENT WILL BE DEDUCTED FROM THE NUMBER OF REMAINING APPOINTMENTS IN THAT PACKAGE.

THANK YOU FOR YOUR UNDERSTANDING,

The People's Clinic

SIGNATURE _____ DATE ___/___/___

PRINTED NAME _____